DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185259	A. BUILDING _____ B. WING _____	07/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF PROSPECT	6301 BASS ROAD PROSPECT, KY 40059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended CMS 2567L issed to facility on 09/10/10. A standard health survey and abbreviated survey were initiated on 07/27/10 and concluded on 07/29/10. Complaint KY 00014703 was found to be unsubstantiated. A life safety code survey was initiated and concluded on 07/29/10 and found the facility not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at an "F".	F 000	Britthaven acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Britthaven's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to allow one (1) of nineteen (19) sampled residents to make choices about the aspects of his/her life to live outside of the facility. (Resident #9) The findings include: Review of the clinical record for Resident #9 revealed the resident was admitted on 04/30/07 for rehabilitation of a fractured hip. The diagnoses for the resident included	F 242	F-242 Discharge planning was initiated for resident #9 on 7/26/2010 by our Social Worker. Resident #9 has expressed a desired discharge goal of 8/28/2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Bettie M. Parker-Turner — TITLE: X Administrator — (X6) DATE: 9/10/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
SEP 10 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 242	Continued From page 1 Osteo-arthritis, Dementia, and Anxiety. The facility completed an annual Minimal Data Set (MDS) assessment on 01/20/10 which indicated Resident #9 was responsible for self. Observation on 07/27/10 at 4:30pm revealed Resident #9 was independent with meals and did not require clothing protector while he/she ate. Continued observation at 5:00pm revealed the resident ambulated outside with cigarettes and lighter with no staff supervision. On 07/28/10 the resident was observed in the dining room feeding his/her self. The resident was clean and free of odors. Throughout the day the resident ambulated freely without assistance and was totally independent with Activities of Daily Living. Interview on 07/28/10 at 10:00am with Resident #9 revealed he/she was admitted for rehabilitation Services with a fracture hip in 2007. The resident related that after recovery from the fractured hip he/she has been totally independent with activities of daily living and only using the call light once in three (3) years. The resident further revealed he/she had expressed a desire to leave the facility with two (2) other social workers prior to the current social worker. Resident #9 revealed that he/she spoke with the current social worker and requested to leave the facility and go to alternate housing until he/she was able to find a boarding room but the resident was told that was not possible and stated " I feel like I'm in a dessert drying up being here ". Interview on 07/28/10 at 12:00pm with the Social Worker revealed she was unsure of having a discussion with Resident #9 regarding discharge to alternate housing. She further stated that about a year ago the resident was experiencing	F 242	**F-242 continued;** Current residents will be interviewed by our Social Worker to ensure each resident is allowed to make their own choice about the aspect of their life to live outside of the Nursing Facility. Residents will continue to be assessed through the R.A.I. processes quarterly, annually & with any significant change in their condition to ensure they are allowed to make their own choice about the aspect to live outside of the facility. Facility staff will be re-educated by the Director of Nursing on August 26, 2010 regarding resident's rights to include that all residents have the right to choose activities, schedules, and health care consistent with his or her interest, assessments, and plans of care; interact with members of the community both inside and outside of the facility; and make choices about aspects of his or her life in the facility that are significant to the resident and that the Social	

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F 242	Continued From page 2 some confusion. The Social Worker stated that the resident has always been his/her own responsible person and indicated the alternate housing expressed by the resident was not an option. Interview on 07/29/10 at 3:00pm with the Administrator revealed he was unaware of Resident #9's desire to leave the facility. The Administrator further stated that the resident would need a better option than the current one suggested. Telephone interview on 07/29/10 at 8:30pm with Licensed Practical Nurse #3 revealed she has been employed for seven (7) months. The LPN stated that she is very familiar with Resident # 9. She reported the resident's need was medication management. She stated that she has never witnessed Resident #9 confused. She reported that the resident had stated several times of the desire to leave the facility. She related that notes were left with the Social Worker, which stated the resident's desire to leave the facility.	F 242	**F-242 continued;** Worker and the Director of Nursing must be made aware if any resident expresses a desire to leave the facility to ensure proper discharge planning can be initiated. A random monthly Q.I. audit will be initiated by the Director of Nursing to ensure resident's choices about the aspects of his/her life to live outside the facility are being honored and that discharge planning has been initiated as appropriate with corrective actions taken as necessary. The results of these Q.I. audits will be reviewed with the Administrator and the Medical Director in the monthly Q.I. meetings.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure medically-related social services were provided	F 250	**Completion Date; August 31, 2010** **F-250** Application for a new social security card for resident #9 was initiated by our Social Services Director on 8/6/2010.	

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F 250	Continued From page 3 for one (1) of nineteen (19) sampled residents. Resident #9 failed to get assistance in obtaining a social security card for discharge back to the community. The findings include: Review of the clinical record for Resident #9 revealed the resident was admitted on 04/30/07 for rehabilitation for a fractured hip. The diagnoses for the resident included Osteo-arthritis, Dementia and Anxiety. The facility completed an annual Minimal Data Set (MDS) assessment on 01/20/10 which indicated the resident was responsible for self. Interview with Resident #9 on 07/28/10 at 10:00am revealed the resident was admitted for rehabilitation with a hip fracture in 03/07. The resident reported he/she has been totally independent with activities of daily living since recovery. The resident stated he/she had only used the call light once in three (3) years. The resident reported his/her desire to leave the facility with two other social workers prior to the current social worker. The resident reported he/she requested the help of the social worker to obtain a social security card, and as of today the resident has not been assisted in obtaining one. Interview with the Social Worker on 07/28/10 at 12:00pm revealed she was unsure of Resident #9's need for a social security card. The Social Worker revealed that she would be willing to assist the resident now. Also, the Social Worker revealed that she had started on possible discharge placement as of Monday 07/26/10. The Social Worker revealed that no discharge planning had been assessed for the resident prior	F 250	**F-250 continued;** An audit of current residents will be completed by the Admissions Director to ensure residents have received medically related Social Services assistance to obtain a social security card if needed. Any resident who does not have a social security card will be provided assistance to obtain one. New residents will continue to have medically related social services provided upon admission to obtain social security cards as needed. The Admissions Director and Social Services Director will be re-educated by the Director of Nursing and / or the Administrator on 8/26/2010, to provided medically related social services to attain the highest practicable physical, mental, and psychosocial well being of each resident including providing assistance in obtaining a social security card for discharge back into the community.	

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F 250	Continued From page 4 to 07/26/10. Record review on 07/27/10 revealed no documentation of discharge planning. The record (Social Narrative Progress Note) revealed a social service narrative dated 07/28/10 at 12:25pm discussing possible discharge to a state transitions agency.	F 250	**F-250 continued;** A random monthly Q.I. audit will be initiated by the Director of Nursing to ensure each resident has received medically related social services assistance to obtain a social security card if needed with corrective action taken as necessary. The results of these audits will be reviewed with the Administrator and Medical Director in the Monthly Q.I. Committee Meeting. **Completion Date; August 31, 2010**	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, clean, homelike environment free from the potential of safety risks related to a black substance located around the base of toilets, an uneven floor surface located between the front hall entrance which leads to the nurse's station, and an uneven surface in front of the third street hall entrance. The findings include: Observations during initial tour of the facility on 07/29/10 at 2:30pm revealed rooms 2, 4, 45, 50 and 53 had a black substance around the base of the toilets in those rooms with strong urine smells in the residents' bathrooms. Observations made at 4:20pm the same day, with the Maintenance Director, revealed an uneven floor with a change	F 252	**F-252** The commodes in rooms #2, 4, 45, 50, and 53; have been taken up, the floor area cleaned thoroughly and tile replaced as needed. The commode was replaced with a new wax seal and anchor bolts. The commode was sealed around the bottom edge with a bead of silicone caulk. The Maintenance Director and Housekeeping Supervisor will continue this process on a regular schedule until all commodes in the facility that need to be resealed, has been completed.	

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F 252	Continued From page 5 in height of about 2 inches located between the front hall entrance, which leads to the nurse's station. Observation on 07/27/10 at 4:00pm revealed Resident #13 was in a shower-chair being assisted by staff; the shower-chair wheel got hooked into a circular dip in the floor, outside the third street hallway. Resident #13 fell forward in the shower-chair and the staff pushing the resident placed her hand in front of the resident to prevent a fall from occurring. Resident #13 stated "Oops there goes the hole again". Interview with the Maintenance Director on 07/29/10 at 4:05pm revealed the toilets needed to be pulled up and resealed around the toilet base. Housekeeping can clean all day and the black substance would not come up. After being asked about the uneven floor in the front hall entrance and the uneven floor outside of the third street hall, the Maintenance Director stated that the surveyor could just write it up and they would fix it. Interview with the Director of Nursing (DON) on 07/29/10 at 4:30pm revealed that she was not aware of Resident #13's shower-chair tipping, into a dip in the floor outside of third street hall, while being pushed in shower-chair by staff. The DON further stated that she has no record of falls occurring because of the dip in the floor outside of the third street hall. Interview with the Administrator on 07/29/10 at 4:50pm revealed he was unaware of the issue with the caulking around the toilet bases and the small dip outside of the third street hall. The Administrator further stated that the dip in the front doorway has been an ongoing issue.	F 252	**F-252 Continued;** The transition strip in the front entrance hallway has been replaced with a ten inch wide stainless steel panel that will form a ramp between the two areas of the hallway. This ramp will remove any tripping hazard and will allow for easier access thru the hallway for those residents in wheelchairs. The circular floor drain in the area near the nurse's station on Third Street hallway; has been covered with a removable 12 inch stainless steel cover that matches up with the surrounding tile to form flat smooth surface. The additional floor drains in the facility have been checked and do not pose a tripping or tipping hazard because they are level with the surrounding tile and form a flat, smooth surface. **Completion Date August 27, 2010**	

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F 000	INITIAL COMMENTS A standard health survey and abbreviated survey were initiated on 07/27/10 and concluded on 07/29/10. Complaint KY 00014703 was found to be unsubstantiated. A life safety code survey was initiated and concluded on 07/29/10 and found the facility not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at an "F".	F 000	Britthaven acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Britthaven's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to allow one (1) of nineteen (19) sampled residents to make choices about the aspects of his/her life to live outside of the facility. (Resident #9) The findings include: Review of the clinical record for Resident #9 revealed the resident was admitted on 04/30/07 for rehabilitation of a fractured hip. The diagnoses for the resident included Osteo-arthritis, Dementia, and Anxiety. The facility completed an annual Minimal Data Set (MDS) assessment on 01/20/10 which indicated	F 242	**F-242** Discharge planning was initiated for resident #9 on 7/26/2010 by our Social Worker. Resident #9 has expressed a desired discharge goal of 8/28/2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X Jim Kennedy X | X ADMINISTRATOR X | 8/20/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	Continued From page 1 Resident #9 was responsible for self. Observation on 07/27/10 at 4:30pm revealed Resident #9 was independent with meals and did not require clothing protector while he/she ate. Continued observation at 5:00pm revealed the resident ambulated outside with cigarettes and lighter with no staff supervision. On 07/28/10 the resident was observed in the dining room feeding his/her self. The resident was clean and free of odors. Throughout the day the resident ambulated freely without assistance and was totally independent with Activities of Daily Living. Interview on 07/28/10 at 10:00am with Resident #9 revealed he/she was admitted for rehabilitation Services with a fracture hip in 2007. The resident related that after recovery from the fractured hip he/she has been totally independent with activities of daily living and only using the call light once in three (3) years. The resident further revealed he/she had expressed a desire to leave the facility with two (2) other social workers prior to the current social worker. Resident #9 revealed that he/she spoke with the current social worker and requested to leave the facility and go to alternate housing until he/she was able to find a boarding room but the resident was told that was not possible and stated " I feel like I'm in a dessert drying up being here ". Interview on 07/28/10 at 12:00pm with the Social Worker revealed she was unsure of having a discussion with Resident #9 regarding discharge to alternate housing. She further stated that about a year ago the resident was experiencing some confusion. The Social Worker stated that the resident has always been his/her own responsible person and indicated the alternate	F 242	**F-242 continued;** Current residents will be interviewed by our Social Worker to ensure each resident is allowed to make their own choice about the aspect of their life to live outside of the Nursing Facility. Residents will continue to be assessed through the R.A.I. processes quarterly, annually & with any significant change in their condition to ensure they are allowed to make their own choice about the aspect to live outside of the facility. Facility staff will be re-educated by the Director of Nursing on August 26, 2010 regarding resident's rights to include that all residents have the right to choose activities, schedules, and health care consistent with his or her interest, assessments, and plans of care; interact with members of the community both inside and outside of the facility; and make choices about aspects of his or her life in the facility that are significant to the resident and that the Social	

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F 242	Continued From page 2 housing expressed by the resident was not an option. Interview on 07/29/10 at 3:00pm with the Administrator revealed he was unaware of Resident #9's desire to leave the facility. The Administrator further stated that the resident would need a better option than the current one suggested. Telephone interview on 07/29/10 at 8:30pm with Licensed Practical Nurse #3 revealed she has been employed for seven (7) months. The LPN stated that she is very familiar with Resident # 9. She reported the resident's need was medication management. She stated that she has never witnessed Resident #9 confused. She reported that the resident had stated several times of the desire to leave the facility. She related that notes were left with the Social Worker, which stated the resident's desire to leave the facility.	F 242	**F-242 continued;** Worker and the Director of Nursing must be made aware if any resident expresses a desire to leave the facility to ensure proper discharge planning can be initiated. A random monthly Q.I. audit will be initiated by the Director of Nursing to ensure resident's choices about the aspects of his/her life to live outside the facility are being honored and that discharge planning has been initiated as appropriate with corrective actions taken as necessary. The results of these Q.I. audits will be reviewed with the Administrator and the Medical Director in the monthly Q.I. meetings. **Completion Date; August 31, 2010**	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure medically-related social services were provided for one (1) of nineteen (19) sampled residents. Resident #9 failed to get assistance in obtaining a social security card for discharge back to the	F 250	**F-250** Application for a new social security card for resident #9 was initiated by our Social Services Director on 8/6/2010.	

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F 250	Continued From page 3 community. The findings include: Review of the clinical record for Resident #9 revealed the resident was admitted on 04/30/07 for rehabilitation for a fractured hip. The diagnoses for the resident included Osteo-arthritis, Dementia and Anxiety. The facility completed an annual Minimal Data Set (MDS) assessment on 01/20/10 which indicated the resident was responsible for self. Interview with Resident #9 on 07/28/10 at 10:00am revealed the resident was admitted for rehabilitation with a hip fracture in 03/07. The resident reported he/she has been totally independent with activities of daily living since recovery. The resident stated he/she had only used the call light once in three (3) years. The resident reported his/her desire to leave the facility with two other social workers prior to the current social worker. The resident reported he/she requested the help of the social worker to obtain a social security card, and as of today the resident has not been assisted in obtaining one. Interview with the Social Worker on 07/28/10 at 12:00pm revealed she was unsure of Resident #9's need for a social security card. The Social Worker revealed that she would be willing to assist the resident now. Also, the Social Worker revealed that she had started on possible discharge placement as of Monday 07/26/10. The Social Worker revealed that no discharge planning had been assessed for the resident prior to 07/26/10. Record review on 07/27/10 revealed no	F 250	**F-250 continued;** An audit of current residents will be completed by the Admissions Director to ensure residents have received medically related Social Services assistance to obtain a social security card if needed. Any resident who does not have a social security card will be provided assistance to obtain one. New residents will continue to have medically related social services provided upon admission to obtain social security cards as needed. The Admissions Director and Social Services Director will be re-educated by the Director of Nursing and / or the Administrator on 8/26/2010, to provided medically related social services to attain the highest practicable physical, mental, and psychosocial well being of each resident including providing assistance in obtaining a social security card for discharge back into the community.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185259	A. BUILDING _____ B. WING _____	07/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF PROSPECT	6301 BASS ROAD PROSPECT, KY 40059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 4 documentation of discharge planning. The record (Social Narrative Progress Note) revealed a social service narrative dated 07/28/10 at 12:25pm discussing possible discharge to a state transitions agency.	F 250	**F-250 continued;** A random monthly Q.I. audit will be initiated by the Director of Nursing to ensure each resident has received medically related social services assistance to obtain a social security card if needed with corrective action taken as necessary. The results of these audits will be reviewed with the Administrator and Medical Director in the Monthly Q.I. Committee Meeting. **Completion Date; August 31, 2010**	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, clean, homelike environment free from the potential of safety risks related to a black substance located around the base of toilets, an uneven floor surface located between the front hall entrance which leads to the nurse's station, and an uneven surface in front of the third street hall entrance. The findings include: Observations during initial tour of the facility on 07/29/10 at 2:30pm revealed rooms 2, 4, 45, 50 and 53 had a black substance around the base of the toilets in those rooms with strong urine smells in the residents' bathrooms. Observations made at 4:20pm the same day, with the Maintenance Director, revealed an uneven floor with a change in height of about 2 inches located between the front hall entrance, which leads to the nurse's station. Observation on 07/27/10 at 4:00pm	F 252	**F-252** The commodes in rooms #2, 4, 45, 50, and 53; have been taken up, the floor area cleaned thoroughly and tile replaced as needed. The commode was replaced with a new wax seal and anchor bolts. The commode was sealed around the bottom edge with a bead of silicone caulk. The Maintenance Director and Housekeeping Supervisor will continue this process on a regular schedule until all commodes in the facility that need to be resealed, has been completed.	

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F 252	Continued From page 5 revealed Resident #13 was in a shower-chair being assisted by staff; the shower-chair wheel got hooked into a circular dip in the floor, outside the third street hallway. Resident #13 fell forward in the shower-chair and the staff pushing the resident placed her hand in front of the resident to prevent a fall from occurring. Resident #13 stated "Oops there goes the hole again". Interview with the Maintenance Director on 07/29/10 at 4:05pm revealed the toilets needed to be pulled up and resealed around the toilet base. Housekeeping can clean all day and the black substance would not come up. After being asked about the uneven floor in the front hall entrance and the uneven floor outside of the third street hall, the Maintenance Director stated that the surveyor could just write it up and they would fix it. Interview with the Director of Nursing (DON) on 07/29/10 at 4:30pm revealed that she was not aware of Resident #13's shower-chair tipping, into a dip in the floor outside of third street hall, while being pushed in shower-chair by staff. The DON further stated that she has no record of falls occurring because of the dip in the floor outside of the third street hall. Interview with the Administrator on 07/29/10 at 4:50pm revealed he was unaware of the issue with the caulking around the toilet bases and the small dip outside of the third street hall. The Administrator further stated that the dip in the front doorway has been an ongoing issue.	F 252	**F-252 Continued;** The transition strip in the front entrance hallway has been replaced with a ten inch wide stainless steel panel that will form a ramp between the two areas of the hallway. This ramp will remove any tripping hazard and will allow for easier access thru the hallway for those residents in wheelchairs. The circular floor drain in the area near the nurse's station on Third Street hallway; has been covered with a removable 12 inch stainless steel cover that matches up with the surrounding tile to form flat smooth surface. The additional floor drains in the facility have been checked and do not pose a tripping or tipping hazard because they are level with the surrounding tile and form a flat, smooth surface. **Completion Date August 27, 2010**	
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456		

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F 456	Continued From page 7 that glucose monitoring was performed only on 06/01/10, 06//02/10, 06/04/10, 06/07/10 all quality checks were performed on 3rd shift. An interview with Licensed Practical Nurse (LPN) #1 on 07/27/10 at 4:00pm revealed the glucose monitoring system should be checked for quality every shift and logged in the quality book located at nurse's station. An interview with the Unit Manager on 07/27/10 at 4:45pm revealed the last logged in recorded in the glucose monitoring log book was dated 02/2008. The Unit Manager stated she/he is unsure if blood glucose monitoring log is kept elsewhere. An interview with the Director of Nursing (DON) on 07/28/10 at 7:45am, revealed that she had in-serviced her staff on 07/27/10 regarding glucometers quality monitoring log system. The DON also revealed that glucose meter quality checks were addressed on 11/19/09 at a nurses meeting. The DON stated the importance of glucometer quality monitoring system to ensure reading of the gluco-meter accuracy of the glucometer.	F 456	**F-456 continued;** The facility will have the Ward Clerk / designee review glucometer checks daily to ensure nurses are completing the test. Ward clerk / designee will report findings to the Unit manager and the Director of Nursing. The Director of Nursing / designee will review the Ward Clerk's monitoring logs weekly for 3 months, then monthly for 6 months to ensure completion and accuracy. The glucometer plan of correction will be reviewed at the monthly Q.I. committer meeting to ensure effectiveness. **Completion Date August 19, 2010**	

Exhibit A

NOTE: The following Sample Policy and Procedure is provided only as an example to help your facility establish your own policies and procedures. Your own policy may vary depending upon your facilities existing procedures. Please consult with your Director of Nursing for further direction.

Policy: Quality Control Testing on Assure Pro Meter

Quality control testing using the Assure Pro Control Solution will be performed to examine the performance of the Assure Pro Blood Glucose Monitoring System.

The Assure Pro Control Solution checks if the meter and test strips are working correctly as a system and if you are testing correctly.

Perform a Control Solution Test:

- Before testing with the Assure Pro System for the first time
- When you open a new bottle of test strips
- Whenever you suspect the meter or test strips may not be functioning properly
- If test results appear to be abnormally high or low or are not consistent with clinical symptoms
- The test strip bottle has been left open or has been exposed to light, temperatures below 34°F (4°C) or above 86°F (30°C), or humidity levels above 80%
- To check your technique

When the Assure Pro Meter has been dropped or stored below 32°F (0°C) or above 122°F (50°C).

IMPORTANT: Depending on state regulations, control solution testing may be required on a daily basis. Please check with your local inspector's regulations or facility procedures.

Important:

- Assure Pro Control Solution is not intended for human consumption. Do not drink.
- Only use with Assure Pro Blood Glucose Meter and Assure Pro Test Strips.
- NEVER touch tip of control solution bottle to test strip!
- Dye in control solution may stain clothing or surfaces.
- Store the control solution between 59-86°F (15-30°C).
- Keep away from direct sunlight and heat. Do not freeze or refrigerate.
- Use before the expiration date printed on bottle.
- Use the control solution within 90 days (3 months) of first opening. It is recommended that you write the date of opening on the control solution bottle label ("Date Opened") as a reminder to dispose of the opened solution after 90 days.
- Always replace the cap immediately after use.
- To avoid contamination do not touch the tip of the bottle to the test strip.
- Assure Pro Control Solution is not a cleaning solution. Do not clean your meter with control solution.

Level of Responsibility: RN/LPN

exhibit B

COMPLETE IN-SERVICE TRAINING REPORT
WITH STAFF ATTENDING

Facility: BOP Department: NSG

Date: 11-16-9 & 11-19-9 Time: To:

Meeting area: Nurses Station / DON office

Employee group(s) present: License nurses

Total number of employees in group(s):

Number present: Number not present:

Subject(s) covered: See Attached

Problems, comments, suggestions:

Conducted by: Tamika Gidron, RN

Title: DON

Signature: Tamika Gidron, RN Title:

BN 1030 Rev. 11/30/07

(OVER)